STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HOUSE	2770 S ADAMS RD BLOOMINGTON, IN47403

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R0000	This visit was for a Post Survey Revisit (PSR) to the PSR completed on 5/9/11 to the State Residential Licensure Survey completed on 02/21/11. Survey Date: 07/11/11 Facility Number: 004016 Provider Number: 004016 Aim Number: NA Survey Team: Melinda Lewis RN TC Marla Potts RN Census by Bed Type: Residential: 35	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 35 Census by Payor Source: Other: 35 Total: 35 Sample: 03 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 7/12/11 Cathy Emswiller RN			
R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to implement a plan for a resident with a known risk of elopement from exiting the facility for 1 of 1 residents reviewed for elopement in a sample of 3.	R0052	**Citation #1 IDR Request face to face meeting R 052 410 IAC 16.2-5-1.2 (v) (1-6) Residents' Rights** We respectfully diagree with this citation and Have requested an Informal Dispute resolution meeting. This Plan of Correction is being provided as	08/24/2011

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	Resident # 1 Findings include: On 7/11/11 at 10:30 A.M., Resident # 1 was observed in his apartment. During interview at that time, Resident # 1 was unable to state the current date, day of the week, and was not able to state location prior to moving to this facility. The clinical record for Resident # 1 was reviewed on 7/11/11 at 10:00 a.m. The record indicated Resident # 1 had diagnoses which included, but were not limited to, cognitive deficit. A dictated physician office visit, dated 4/27/11, indicated "...Patient here to follow-up cognitive deficit...He may be mildly better, He seems to be thinking better..." The Service Assessment/Negotiated Service Plan, dated 6/22/11, indicated "...Comments: exit seeking fairly easy to reorient 15 min check..." In an interview with the Admission Coordinator, on 7/11/11 at 1:30 P.M., she indicated the service assessment/negotiated service plan, dated 6/22/11, was the form that was used during the preadmission evaluation. She		required by state law. **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident #1 entered our community and was assessed by a licensed nurse and found to be alert and oriented to person, place, and time with a mini mental score of 29. Resident's physician prior to admission felt resident was cognitively able to self administer medications based upon his assessment and knowledge of the resident's medical condition. Resident is capable of making his own decisions based on clinical observation and documentation provided. After Resident #1 went outside on June 28, 2011 the Wellness Director had a urinalysis and blood work ordered to rule out acute care changes related to a potential "significant change" due to intermittent confusion. Monroe House has began to administer medication for this resident until a medical evaluation by the resident's attending physician is completed. Sign posted at Residence in entry way asks visitors not to let residents enter or exit community without staff knowledge. Signage was posted on the doorway upon entering and exiting the building in effort to minimize the risk for exit seeking behaviors for those residents	

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	stated that the previous Wellness Director and herself had done the assessment of Resident # 1 together. The Discharge Checklist, dated 6/24/11, indicated "...Pt [patient] currently on 15 min [minute] checks due to elopement risk..." The Resident Services Notes, 6/28/11 0900 (9:00 A.M.), indicated "Local repair man let resident out of facility upon entering. Res [resident] was seen leaving facility by Activity Director (name) and was immediately escorted back into building. This RN assessed res upon re-entry, no injuries. Family and MD notified." The Elopement Risk Assessment, dated 6/29/11, indicated "...Past history of elopement or exit seeking behavior, Change in usual orientation, confusion, agitation or pattern of wandering, disorientation or intermittent confusion...Any bold item- Even one of these items indicates a potential for elopement and requires consultation with the regional team and appropriate intervention..." Two of the circumstances/behaviors identified were bold. In an interview with RN # 1, on 7/11/11 at		considered to be “at risk.” Even though Monroe House does not consider resident #1 to be an exit seeker Monroe House has alerts in place such as the updated service level assessment and negotiated service plan for this individual to include services rendered by our staff to ensure the resident’s scheduled and unscheduled needs. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents considered “at risk” for exit seeking behavior were re-evaluated by a licensed nurse utilizing our service level assessment and negotiated service plan with interventions implemented to minimize the risk for future behaviors. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The new Wellness Director and Residence Director were educated to our policy and procedure regarding our service level assessment, elopement protocol, task sheets, and Behavioral Management Plan. Residents considered “at risk” for exit seeking and/or elopement behaviors will be carefully evaluated with	

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	10:15 A.M., she indicated Resident # 1 was observed by the Activity Director outside in the parking lot. She indicated the Activity Director was not sure if the person observed in the parking lot was a resident or not, but she assumed he was a new admission as he was going from car to car. In an interview with the Regional Nurse, on 7/11/11 at 11:30 A.M., he indicated when Resident # 1 eloped on 6/28/11 the facility talked with the vendors and instructed them not to let residents out the doors. He further indicated there had been a sign on the door to inform visitors and vendors not to assist residents outside. He further indicated Resident # 1's behavior was new and he had contacted the physician himself. A Physician Fax Transmission/Phone Order, dated 6/30/11, indicated "...Family and writer has observed some change in this residents condition. Resident came to us alert and oriented x [times] 3 and well able to manage medications after being set up in med [medication] planner by daughter due to change I have removed med planner contacted family and am administering meds. May we do a U/A [urinalysis]?..." A Fax Error Report , dated 6/30/11 at 11:32 (no A.M. or P.M.), indicated "...Busy/No signal..."		interventions developed and Implemented in effort to minimize the risk for potential behavioral disturbance. Residents will be identified via the task sheet with interventions provided on the service plan. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director will perform a random monthly review of residents at the Monroe House for a period of six months to ensure residents considered “at risk” for exit seeking and/or elopement are adequately assessed with interventions developed to minimize the risk for behavioral disturbance through utilization of the service level assessment and task sheets. Findings will be reviewed within six months to determine ongoing monitoring plan. Findings suggestive of compliance will result in no need for routine monitoring per our plan. **By what date will the systemic changes be completed?** Compliance Date: 8/24/11	

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	On 7/11/11 at 12:30 P.M., the entry way was observed for the posting of a sign to inform visitors not to assist residents outside. There was a sign observed hanging above the key pad to exit the facility however there was no other signs observed to inform visitors upon entering the facility not to assist residents outside. On 7/11/11 at 1:15 P.M., in an interview with CNA # 1 she indicated Resident # 1 was checked every 30 minutes for his location. She indicated these checks had been started after Resident # 1 had been let out of the facility. She indicated that there was a sheet of paper to document the 30 minute checks done on Resident # 1 but she was unable to provide any of the completed check forms. She stated she thought the completed forms were kept in the resident's clinical record. When CNA # 1 was asked where today's sheet was located she stated there is not one for today. She stated I guess they ran out of forms and just haven't printed anymore. The PSA [Personal Service Assistant] Task Sheet for 6a-2p, 2p-10p, and 10p-6a were reviewed on 7/11/11 at 1:15 P.M. The sheets indicated "...Risks: Elopement:..." The list included the room number for 4 residents. Resident # 1's room was not listed on the risks for			

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	elopement. In an interview with CNA # 1, on 7/11/11 at 1:20 P.M., she indicated she had worked in the facility for about 2 months. She indicated the task sheets had not been updated for at least 2 to 3 weeks. This state residential finding was cited on 2/21/11 and 5/9/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to implement an individualized service plan related to	R0217	**Citation #2 IDR Request R 217 410 IAC 16.2-5-2 (e) (1-5)** **Evaluation** We respectfully diagree with this citation and	08/24/2011

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	personal safety for 2 of 3 residents reviewed for service plans in a sample of 3. Resident # 1 and 2. Findings include: 1. The clinical record for Resident # 2 was reviewed on 7/11/11 at 12:30 P.M. The record indicated Resident # 2 had diagnoses that included but were not limited to left hip fracture, anxiety, and dementia. The Nursing Comprehensive Evaluation, dated 6/26/11, indicated "...fx [fractured] 1 month prior...Has dementia, anxiety, slightly agitated...Some forgetfulness..." The Service Assessment/Negotiated Service Plan, dated 6/26/11, indicated "...Do you use any type of assistive device for mobility? Have you ever fallen? In the last week, in the last monthly, in the last 3 months, More than 3 months ago, I have never fallen...." All these questions were left blank. The Mobility Management Planning Tool, dated 6/26/11, indicated "...Has resident fallen in the past ninety days?...Yes...Instructions: ...If ANY question is answered "yes" then refer to		Have requested an Informal Dispute resolution meeting. This Plan of Correction is being provided as required by state **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #1 entered our community and was assessed by a licensed nurse and found to be alert and oriented to person, place, and time with a mini mental score of 29. Resident's physician prior to admission felt resident was cognitively able to self administer medications based upon his assessment and knowledge of the resident's medical condition. Resident is capable of making his own decisions based on clinical observation and documentation provided. After Resident #1 went outside on June 28, 2011 the Wellness Director had a urinalysis and blood work ordered to rule out acute care changes related to a potential "significant change" due to intermittent confusion. Monroe House has began to administer medication for this resident until a medical evaluation by the resident's attending physician is completed. Sign posted at Residence in entry way asks visitors not to let residents enter or exit community without staff knowledge. Signage was posted on the doorway upon entering and exiting the building in effort to	

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	the Mobility Management interventions. Choose only interventions that can realistically be accomplished and added to the Negotiated Service Plan [NSP]. (The NSP should reflect appropriate monitoring and interventions.)..." The Resident Services Notes, dated 7/6/11 at 4:30 P.M., indicated "Sent to (Name) hosp [hospital] ER [emergency room] due to fall." The Resident Services Notes, dated 7/6/11 at 7:10 P.M., indicated "Return from (name) hosp. No fx [fracture] L [left] hip just bruised." The Resident Services Notes, dated 7/6/11 at 4:35 P.M., indicated "Resident had experienced a fall and was notified by the family. Upon entry resident was in apt [apartment] in living room. Resident was assessed and noted to have pain in L hip. Writer kept resident comfortable and instructed PSA to contact 911 to have resident transferred to (name) hospital per family..." 2. The clinical record for Resident # 1 was reviewed on 7/11/11 at 10:00 a.m. The record indicated Resident # 1 indicated diagnoses that included but were not limited to cognitive deficit.		minimize the risk for exit seeking behaviors for those residents considered to be “at risk.” Even though Monroe House does not consider resident #1 to be an exit seeker Monroe House has alerts in place such as the updated service level assessment and negotiated service plan for this individual to include services rendered by our staff to ensure the resident’s scheduled and unscheduled needs. Resident #2 was admitted to Monroe House at a base level and was considered independent with ambulation, medication management, ADL’s, and IADL’s. Resident ambulated without assistive device and had a fall on 7/6/11 with an admitting D/X of a bruised hip. Resident has been re-assessed by the Regional Director of Quality and Care Management with the service plan updated to include interventions to minimize the risk for falls with injury including a call pendant that was arranged prior to survey and placed on the day of re-survey by the Regional Maintenance Director on 7/11/11. Resident is currently receiving therapy and is utilizing a walker to assist with ambulation. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Regional Director of Quality and Care	

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	The Service Assessment/Negotiated Service Plan, dated 6/22/11, indicated "...Comments: exit seeking fairly easy to reorient 15 min check..." In an interview with the Admission Coordinator, on 7/11/11 at 1:30 P.M., she indicated the service assessment/negotiated service plan, dated 6/22/11, was the form that was used during the preadmission evaluation. She stated that the previous Wellness Director and herself had done the assessment of Resident # 1 together. The Discharge Checklist, dated 6/24/11, indicated "...Pt [patient] currently on 15 min [minute] checks due to elopement risk..." The Resident Services Notes, 6/28/11 0900 (9:00 A.M.), indicated "Local repair man let resident out of facility upon entering. Res [resident] was seen leaving facility by Activity Director (name) and was immediately escorted back into building. This RN assessed res upon re-entry, no injuries. Family and MD notified." In an interview with RN # 1, on 7/11/11 at 10:15 A.M., she indicated Resident # 1 was observed by the activity director outside in the parking lot. She indicated		Management re-assessed new admissions for the past 6 months and updated the service level assessment to include provisions to be performed by staff to enhance our residents overall quality of care along with their scheduled/unscheduled needs. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The new Wellness Director and Residence Director were re-educated to our policy and procedure concerning our service level assessment, task sheets, and communication log. The Wellness Director and/or Residence Director will ensure residents are assessed and re-assessed utilizing the service level assessment, task sheets, and communication log to ensure our residents scheduled and unscheduled needs are met. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Residence Director will perform an ongoing assessment of residents prior to admission, semi annually, and with a change of condition to ensure resident's scheduled/unscheduled needs are met. **By what date will the systemic changes be**	

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	the activity director was not sure if the person observed in the parking lot was a resident or not, but she assumed he was a new admission as he was going from car to car. In an interview with the Regional Nurse, on 7/11/11 at 11:30 A.M., he indicated when Resident # 1 eloped on 6/28/11 the facility talked with the vendors and instructed them not to let residents out the doors. He further indicated there had been a sign on the door to inform visitors and vendors not to assist residents outside. He further indicated Resident # 1's behavior was new and he had contacted the physician himself. A Physician Fax Transmission/Phone Order, dated 6/30/11, indicated "...Family and writer has observed some change in this residents condition. Resident came to us alert and oriented x [times] 3 and well able to manage medications after being set up in med [medication] planner by daughter due to change I have removed med planner contacted family and am administering meds. May we do a U/A [urinalysis]?..." A Fax Error Report , dated 6/30/11 at 11:32 (no A.M. or P.M.), indicated "...Busy/No signal..." On 7/11/11 at 12:30 P.M., the entry way was observed for the posting of a sign to		**completed?** Compliance Date: 8/24/11	

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	inform visitors not to assist residents outside. There was a sign observed hanging above the key pad to exit the facility however there was no other signs observed to inform visitors upon entering the facility not to assist residents outside. On 7/11/11 at 1:15 P.M., in an interview with CNA # 1 she indicated Resident # 1 was checked every 30 minutes for his location. She indicated these checks had been started after Resident # 1 had been let out of the facility. She indicated that there was a sheet of paper to document the 30 minute checks done on Resident # 1 but she was unable to provide any of the completed check forms. She stated she thought the completed forms were kept in the resident's clinical record. When CNA # 1 was asked where today's sheet was located she stated there is not one for today. She stated I guess they ran out of forms and just haven't printed anymore. The PSA [Personal Service Assistant] Task Sheet for 6a-2p, 2p-10p, and 10p-6a were reviewed on 7/11/11 at 1:15 P.M. The sheets indicated "...Risks: Elopement:..." The list included the room number for 4 residents. Resident # 1's room was not listed on the risks for elopement. In an interview with CNA # 1, on 7/11/11			

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	at 1:20 P.M., she indicated she had worked in the facility for about 2 months. She indicated the task sheets had not been updated for at least 2 to 3 weeks. This state residential finding was cited on 2/21/11 and 5/9/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HOUSE	2770 S ADAMS RD BLOOMINGTON, IN47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE